

Testimony on Behalf of Margaret Condon Taylor, PhD

House Committee on Families, Children and Seniors

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Presented by Judith Kovach, PhD  
Policy Consultant, Michigan Psychological Association  
[mpadpa@msn.com](mailto:mpadpa@msn.com)

As much as I would like Lansing legislators to know of my personal story, my own health compromises my ability to travel to Lansing. I cannot predict how I will feel from day to day. I would like you to tell them on my behalf the following:

After my husband became permanently disabled with bipolar disorder, I bought an individual policy with BCBSM in the early 1990's through the Detroit, and then the Ann Arbor, Chambers of Commerce. The maximum benefit then allowed for mental health coverage was \$5,000 -- spread over the entire lifetime.

I left private practice and resumed employment with the State's Department of Community Health in 2002 in order to provide adequate mental health care coverage for my family.

My young adult daughter was diagnosed with recurrent major depression when she was about eight years old. A few years later, still in the 1990's, she was herself diagnosed with bipolar disorder.

Even with the State of Michigan as employer, my family struggled for many years with carve-outs and managed care limitations on services and on providers.

The State of Michigan as employer offered then, and continues to offer, non-parity mental health coverage through its BCBSM Magellan Behavioral Health carve-out for mental health.

Our family's financial struggle due to lack of parity showed no signs of abating until our daughter qualified for Medicaid health coverage prior to age 18 and for Medicare coverage after age 20.

I want legislators to know the true cost of denying parity to the seriously mentally ill must include the cascade of conditions and consequences flowing from non-parity. I will make this reiterative point below.

- Most caregivers -- more or less in the neighborhood of 80% -- are women: we are mothers, wives, daughters, grandmothers, aunts, sisters, and in-laws.
- I often interviewed these women when they accompanied a relative to the Forensic Center for a son's or husband's evaluation before I had to drop out of the labor force.

I myself pay with fibromyalgia syndrome, with an unwelcome early retirement, with divorce upon the advice of an estate attorney to protect myself from medical bankruptcy.

We women caregivers caring for loved ones in a non-parity State are unpaid help. We are non-parity's hidden domestics. No days off. No holidays. No vacations. Working 24-hour shifts. No end in sight.

Women unduly pay the due bill arising from lack of mental health parity. Women initially pay with their own mental, physical, emotional and economic health. When they can pay no longer pay, the cost shifts. Eventually society pays.

Now I am costing the State and the Federal taxpayers money due to occupational disability. Add the cost of my occupational disability into the cost-benefit analysis used to calculate the true cost burden of non-parity.

Add the cost of my being unable to participate fully in my local community as a volunteer and as a consumer, or as a leader, or even as a private practice clinical psychologist.

Parity's absence in the insurance market place constitutes more than a cost-benefit issue. It is also -- on a daily basis -- a domestic issue, a women's issue.

For a realistic assessment of the true economic and social costs accruing from long-standing practices of discriminatory insurance coverage, I would like to share with our State legislators the importance of tallying discrimination's indirect costs. These indirect costs of maintaining non-parity insurance coverage for mental illness are far from contained.

The items below are garnered from are ones my family and I have personally encountered over the past two decades. When I say "an afflicted family's --" followed by a phrase, I am specifically referring to my own family's experiences, although I have every reason to conclude my family's experiences are neither uncommon nor atypical. These listed items are presented in no particular order:

- an afflicted family's -- increased utilization of special education services from K-12
- an afflicted family's -- inability to finance treatments including outpatient and inpatient services
- an afflicted family's-- increased utilization of emergency services for the mentally ill child
- an afflicted family's -- preoccupation with monitoring a mentally ill child's suicidal ideas, plans, and/or behaviors
- an afflicted family's -- inability to provide a continuously supervised environment for acutely mentally ill child
- an afflicted family's -- increased preoccupation with financial matters including medically-driven bankruptcy
- an afflicted family's -- increased likelihood of parental divorce

- an afflicted family's -- permanent reallocation of financial and emotional resources away from siblings
- an afflicted family's -- loss of ability to fund other educational and retirement savings plans
- an afflicted family's -- abrupt experience of stigmatization -- even by experienced mental health providers
- an afflicted family's -- broad-ranging social dislocation and permanent loss of normal societal reciprocity
- an afflicted family's -- increased utilization of "medical" and "psychiatric" services
- an afflicted family's -- dependence upon a caregiver simultaneously serving as family's sole breadwinner
- an afflicted family's -- worry caregiver's chronic stress will result in poor job performance and/or disability
- an afflicted family's -- growing realization a caregiver's health is permanently compromised
- an afflicted family's -- adaptation to Social Security disability income as a fraction of prior earned income
- an afflicted family's -- loss of ability to pay taxes on the loss of income formerly earned

The afflicted family's concerns inevitably radiate outward to encompass neighbors, teachers, other parents, and their children, to internists, psychiatrists, psychologists, nurses, social workers, lab technicians, lawyers, disability and unemployment officers, guidance and drug counselors, private and public hospitals, ambulance crews, police officers, low income housing personnel, and on and on.

I believe we could be doing better. We could be embracing insurance parity for all severely mentally ill persons beginning in early childhood -- whether their diagnosis is autism, or any other serious mental disorder. Michigan's legislators may wish to postpone enacting parity legislation when such proposed legislation is itself discriminatory, as is the case with current legislative efforts focusing solely on autism.

The Legislators need now to include all severe mental disorders. Autism parity is a wonderful place to begin --and a terrible place to end -- the struggle for parity coverage.